

Group Benefits from The Hartford

Sports Accident Program

Request for Insurance (Enhanced)



New Business Underwriting Company Hartford Life and Accident Insurance Company
 Renewal of Policy No. _____

Coverage will commence on the desired effective date or on the date your Request for Insurance is approved by the Company, whichever is later. The minimum premium is \$310.

1. Policyholder Name: _____
2. Policyholder Address: _____
3. Effective Date _____ Expiration Date _____
4. Please check here if Accident Medical Expense Benefit is desired on an Excess Basis over and above other insurance.
5. Sport(s) to be covered (Use additional sheet, if necessary):

Sport Played	Team Name	Date of First Scheduled Practice Session or Game	Sport End Date	Age Group (12 & Under 13 to 15 16 to 18)	No. of Players Managers and Coaches	X Ind* Prem.	= Team Prem.
						\$	\$
						\$	\$
						\$	\$
						\$	\$
						\$	\$
						\$	\$

* Individual Premium is the sum of the Accident Medical Expense rate and the Accidental Death and Dismemberment rate.
 Please refer to our website at www.accidentlines.com to acquire additional information regarding plans and rates.

6. Coverage:
 - Accidental Death and Dismemberment \$ _____ Maximum Benefit
 - Accident Medical Expense \$ _____ Maximum Benefit
 - Dental Amount \$ 250.00 Maximum Benefit
 - Deductible Amount \$ _____

7. Previous Insurance Yes No
 If a sports accident insurance program has been carried in the past, please give the following details for the past three years.

Policy Year	20 _____	20 _____	20 _____
Total Premium	_____		
Total Paid Claims	_____		
Total Open Reserves	_____		
Total Number of Claims	_____		
Name of Prior Carrier	_____		

No new business can be considered unless the above information is completed.
 Be sure to include a copy of the current policy or certificate.

8. Signature of Person Providing Information: _____
 Title: _____ Date: _____

REQUIRED INFORMATION:

Name of Agent _____ Agency Code _____ License no. _____
 Address: _____
 Signature of Licensed Resident Agent (where required) _____
 Sub-Producer (Agent) Name: _____ License no. _____

Must be Life and Health appointed. Appointment application and license copy for Agent and Sub-Producer required.

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Expertise without equal.
 Benefits without burden.SM